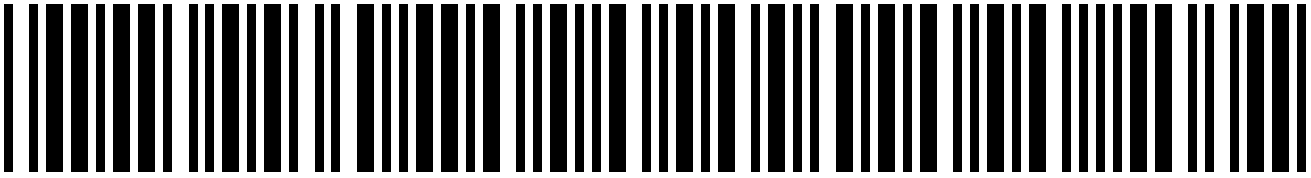
This packet is an example of the order in which documents should be filed. These are not examples of how to fill out forms/documents.

STATE OF CALIFORNIA
DWC DISTRICT OFFICE

DOCUMENT COVER SHEET



Is this a new case? Yes ☐ No ☑ Companion Cases Exist ☐ Walkthrough Yes ☐ No ☑

More than 15 Companion Cases ☐

09/10/2008
Date:(MM/DD/YYYY)

SSN: 000-00-0000

ADJ12345
Case Number 1

☑ Specific Injury
☐ Cumulative Injury

01/13/1999
(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: 420

Body Part 2: 100

Body Part 3:

Body Part 4:

Other Body Parts:

Please check unit to be filed on (check only one box)

☑ ADJ ☐ DEU ☐ SIF ☐ UEF ☐ VOC ☐ INT ☐ RSU

Companion Cases

☐ Specific Injury

Case Number 2

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1:

Body Part 2:

Body Part 3:

Body Part 4:

Other Body Parts:

DOCUMENT SEPARATOR SHEET

Product Delivery Unit ADJ

Document Type LEGAL DOCS

Document Title DECLARATION OF READINESS TO PROCEED

Document Date _____
MM/DD/YYYY

Date of document following Document Separator Sheet

If you are the Claims Administrator or the Hearing Representative use your Uniform Assigned Name. For unrepresented Injured Worker and others, "Author" is the document author.

Author UNIFORM ASSIGNED NAME

Office Use Only

Received Date _____
MM/DD/YYYY

DWC-CA form 10232.2

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
DECLARATION OF READINESS TO PROCEED

NOTICE: Any objection to the proceedings requested by a Declaration of Readiness to proceed shall be filed and served within ten (10) days after service of the Declaration.

Case No.

Applicant

First Name MI

Last Name

VS

Employer Information

Employer Name (Please leave blank spaces between numbers, names or words)

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Declarants: Please designate your role (Please Select Only One)

☐ Employee ☐ Applicant ☐ Defendant ☐ Lien Claimant

Declarant requests: (Please Select Only One)

☐ Mandatory Settlement Conference ☐ Status Conference ☐ Rating MSC* ☐ Priority Conference

At the present time the principal issues are: (Check all that apply)

☐ Compensation Rate ☐ Rehabilitation/SJDB ☐ Temporary Disability ☐ Self-Procured Medical Treatment
☐ Permanent Disability ☐ Future Medical Treatment ☐ AOE/COE ☐ Discovery
☐ Employment ☐ Other

Declarant relies on the report(s) of:

Doctors (s) date
MM/DD/YYYY

*For a Rating MSC, all ratable medical reports, including treating physician, QME and AME reports, must be filed with this Declaration of Readiness, unless they have been previously filed. A Rating MSC will be set only where the issues are limited to permanent disability and the need for future medical treatment.

Declarant states under penalty that he or she is presently ready to proceed to hearing on the issues below and has made the following specific, genuine, good faith efforts to resolve the dispute(s) listed below:

Unless a status or priority conference is requested, I have completed discovery on the issues listed above, and all medical reports in my possession or control have been filed and served as required by the rules promulgated by the Court Administrator.

Copies of this Declaration have been served this date as shown on the attached proof of service.

Declarant's Signature _____

_____
Name and Law Firm (Print or Type)

_____
Address (Please leave blank spaces between numbers, names or words)

_____ Date _____
Phone Number MM/DD/YYYY

DOCUMENT SEPARATOR SHEET

Product Delivery Unit ADJ

Document Type LEGAL DOCS

Answer is included in the Declaration of Readiness to Proceed if filed by the defense and answer not already filed

Document Title ANSWER TO APPLICATION FOR ADJUDICATION OF CLAIM

Date of document following Document Separator Sheet

Document Date _____
MM/DD/YYYY

Author UNIFORM ASSIGNED NAME

Office Use Only

Received Date _____
MM/DD/YYYY

DWC-CA form 10232.2

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
ANSWER TO APPLICATION FOR ADJUDICATION OF CLAIM

Case Number

(Choose only one)

☐ a specific injury on _____
(MM/DD/YYYY)

☐ a cumulative trauma injury which began on _____ and ended on _____
(START DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)

Name(s) of Answering Party(ies) (Please leave blank paces between names, numbers or words)

Injured Worker

Last Name MI

First Name

Employer Information

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words)

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Insurance Carrier Information (if applicable - include even if carrier is adjusted by claims administrator)

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Claims Administrator Information (if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City | State | Zip Code

ANSWERING DEFENDANTS deny the allegations of the application as indicated below with such explanations as expressly set forth and admit all other material allegations.

DENIALS (Mark X if allegation is denied)	**EXPLAIN BELOW**
☐ Employment	
☐ Occupation	
☐ Injury	(IF DENIAL IS BASED ON DATE OR PART OF BODY INJURED, EXPLAIN FULLY)
☐ Insurance coverage	(STATE IF EMPLOYER HAS BEEN NOTIFIED TO APPEAR AND DEFEND)
☐ Liability for self-procured treatment	
☐ Liability for future medical treatment	
☐ Medical-legal costs	
☐ Earnings	

☐ Periods of disability (GIVE LAST DAY WORKED AND CORRECT DATE OF RETURN TO WORK, IF ANY)

☐ Rehabilitation

☐ Supplemental job displacement / return to work

☐ Permanent disability (IF APPORTIONMENT IS CLAIMED, SO STATE)

IT IS FURTHER ALLEGED:

1. Defendants have paid disability indemnity in the total amount of $ _____ at the rate of $ _____

a week beginning _____ (MM/DD/YYYY) through _____ (MM/DD/YYYY) plus _____

2. Affirmative defenses and other matters :

The Answer to this Application is being filed on behalf of (Please check one only)

☐ Employer ☐ Insurance Carrier ☐ Both

Defendant(s) do(es) not waive the right to raise additional issues in accordance with the provisions of law and the Rules of Practice and Procedure if other issues develop.

Dated: _____

_____ Phone Number _____

Signature

_____

Firm Name

_____

Address/PO Box (Please leave blank spaces between numbers, names or words)

_____ _____ _____

City State Zip Code

DOCUMENT SEPARATOR SHEET

Product Delivery Unit ADJ

Document Type LEGAL DOCS

Document Title 4906(g) DECLARATION

Document Date 05/12/2008
MM/DD/YYYY

If you are the Claims Administrator or the Hearing Representative use your Uniform Assigned Name. For unrepresented Injured Worker and others, "Author" is the document author.

Author UNIFORM ASSIGNED NAME

Office Use Only

Received Date
MM/DD/YYYY

DWC-CA form 10232.2

KENT H. BALL
BRADFORD & BARTHEL, LLP
2161 YGNACIO VALLEY ROAD
SUITE 200
WALNUT CREEK, CA. 94598
925-937-1252
Bar No.:

ATTORNEYS FOR DEFENDANTS, NORDSTROM, INC.

BEFORE THE WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

[redacted]

Applicant,

vs.

[redacted]

Defendant(s).

WCAB Case No. [redacted]

DECLARATION PURSUANT TO LABOR CODE SECTION 4906(g)

I, KENT H. BALL,

(the employer, claims adjustor, or attorney for defendant), hereby declare under penalty of perjury that I have not violated Labor Code Section 139.3 and that I have not offered, delivered, received, or accepted any rebate, refund, commission, preference, patronage, dividend, discount or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referral examination or evaluation.

DATED: MAY 12, 2008

Respectfully submitted,

BRADFORD & BARTHEL, LLP

[redacted]

BY: KENT H. BALL
2161 YGNACIO VALLEY ROAD #200
WALNUT CREEK, CA. 94598

DOCUMENT SEPARATOR SHEET

Product Delivery Unit ADJ

Document Type MEDICAL DOCS

Document Title MEDICAL REPORTS

Document Date 09/29/2006
MM/DD/YYYY

Author MEDICAL PROVIDER NAME

Example:
JOHN A SMITH MD
JOHN A SMITH PT
Use only capital letters and no special characters e.g. / \ ' . " , : ; ( ) & !

Office Use Only

Received Date
MM/DD/YYYY

DWC-CA form 10232.2

Kendrick E. Lee, M.D.
Surgery and Microsurgery of the Hand
Webster Orthopaedic Medical Group
80 Grand Avenue, Suite 400
Oakland, CA 94612-3725
510 238 1200 Fax 510 663 1543

Hand Surgery Consultation Report

[redacted]

Patient: [redacted]
Date of birth: November 27, 1942
Employer: [redacted]
Date of Injury: August 19, 2005
Claim number: [redacted]
Date of examination: August 28, 2006
Date of report: September 29, 2006

Dear [redacted]

Thank you for asking me to examine [redacted] for hand surgery consultation.

Chief complaint:
right thumb base pain

History:
[redacted] right handed woman. At the time of her injury she was employed as a espresso bar barista by the Nordstrom Rack store in San Leandro. She had worked there beginning about 1997.

She presents a 4 page history of her right thumb pain. She states that in 1999 she had the gradual onset of right thumb base pain. She reported this in 1999, and was initially treated at Occupational Medicine Associates in San Leandro. "They told me I had arthritis". Treatment included ibuprofen splinting and therapy treatment. "I never got better". She continued at the espresso bar for another year or two, and then the department was closed. She left Nordstrom for about a year, and worked "freelance"

drafting and other work.

She then returned to Nordstrom, working in the men's department beginning about 2002 or 2003. The symptoms persisted. She was subsequently treated at Kaiser for plantar fasciitis. She also asked about her hand and she was told about tendonitis, and she was told that that was work related.

She returned to the worker's comp system, and was treated at Concentra beginning in August 2005. She had additional medication, got another splint, and had therapy at Concentra and Cornerstone. There was temporary improvement with therapy for a couple of days.

In February 2006, she saw [redacted] for what sounds like evaluation. She is not sure what the result of the evaluation was.

Symptoms have not improved. The patient currently complains of right thumb base pain with pinching, such as a clothespin pinch. The pains occur everyday with activities of daily living, episodes can last "all night long". Using a Q tip hurts. Hair care hurts. The symptoms are relieved by rest, or "plunging my hand in a bucket of ice". Ibuprofen helps the pain also for a few hours. She denies numbness, tingling in the right or left, and there are no left hand symptoms.

She has remained at work. She now works doing freelance drafting.

[redacted] is now seen for hand surgery consultation.

Past Medical History:
Prior history of upper extremity complaints or injuries; none
Ongoing medical conditions; none
Prior surgery; gallbladder 2000, tonsils in childhood
Current medications; none
Allergies to medications; ASA causes GI irritation
Tobacco use; none
Alcohol use; none
Regular primary physician;Kaiser

Family and Social History:
Single, no children. She has a cat. She does some drawing for pleasure. She walks for exercise. She does not participate in any sports.

Review of systems:

The patient has had visual "floaters". She has ringing in the ears with aspirin. She denies ongoing symptoms of headache, hearing loss, persistent sore throat, shortness of breath, chest pain, abnormal cough, abdominal pain, blood or burning with urination, blood in bowel movements, menstrual disorders, current pregnancy, or unexplained weight loss.

Records reviewed: (9/29/2006, 15 minutes)

Four-page letter from the patient, setting forth in great detail her duties as a barista, the medical course, the symptoms. Also detailing work as a sales associate.

52 page file of records
4/27/2006, panel QME report [redacted] Diagnosis chronic right thumb tendinitis. Permanent and stationary "at least by October 1, 2005". Future medical treatment includes hand therapy, Dr. visits three or four times a year. Night splints. Medication.

Records from Concentra medical center.
9/14/2005, radial styloid tenosynovitis, resolved.. Arthritis, right thumb carpal metacarpal and metacarpal phalangeal, non-industrial. Released from care at maximum medical improvement, no permanent disability. [redacted]

9/2/2005, right hand metacarpal pharyngeal tenosynovitis. Medication, therapy, activity modification.

8/24/2005, physical therapy visits.

8/19/2005, doctors first report, [redacted]

8/19/2005, [redacted] eQuervain's tenosynovitis, thumb spica splint, ibuprofen, modified duty.

Reports from Occupational Medicine Associates, [redacted]
4/8/1999, right thumb arthritis. Regular work beginning 4/8/1999.
3/23/1999, right thumb arthritis.
Physical therapy notes, from 3/10/1999 to 3/23/1999.
3/8/1999, doctors first report, [redacted] right thumb overuse and arthritis. Use splints.

Physical examination:
[redacted] ppears her stated 5 foot 4 1/2 inch height and 198 lb. weight.

On record review, I note the diagnosis by the more recent treaters and on the QME report was tenosynovitis and chronic thumb tendonitis. Thumb CMC arthritis is an age related condition, which can be aggravated by work exposure. There may be need to ask for QME re evaluation regarding apportionment of the thumb CMC arthritis, which appears to be the ongoing condition.

The nature of the condition was discussed. Treatment options were discussed, and include activity modification, ergonomic changes, medication, splinting, therapy, steroid injection, and ultimately surgery. In fact, she has had all of these except for injection and surgery. She has had non specialist physical therapy splinting, but had not had hand therapy or custom thumb CMC splinting. Symptoms persist, and now impact daily living activities.

I advised a limited course of therapy, with focus on teaching activity modification, and custom short oppenens splinting.

She is scheduled for follow up October 9, 2006. Further treatment might be needed, based upon her symptoms.

I hereby declare under penalty of perjury that I have not violated Labor Code Section 139.3 and that the contents of this report are true to the best of my information and belief. I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information I have indicated I have received from others. As to that *information, I declare under penalty of perjury that the information accurately describes the information* provided to me and, except as noted herein, that I believe it to be true. In compliance with Labor Code Section 5703 (A)(1), I, Kendrick E. Lee, the consulting physician, declare under penalty of perjury that I have not violated Labor Code Section 139.3 and that I have not offered, delivered, received, or accepted any rebate, refund, commission, preference, patronage dividend, discount, or other consideration whether in the form of money or otherwise as compensation or inducement for any referred examination or evaluation.

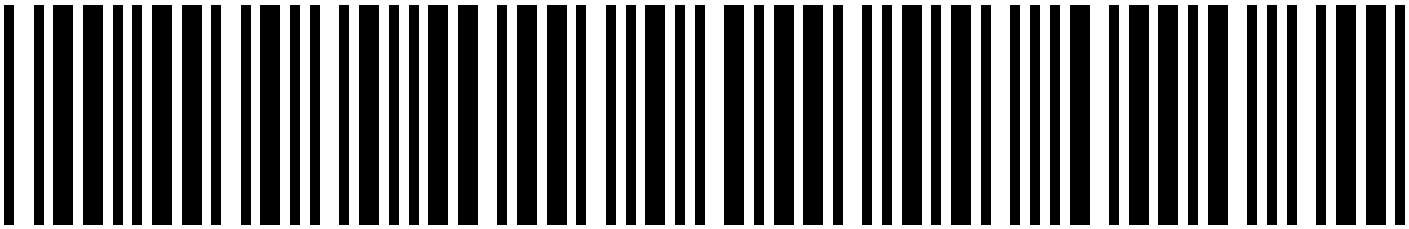
Signed September 29, 2006 in Alameda County, California.

Sincerely,

[redacted]

[redacted]

DOCUMENT SEPARATOR SHEET



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Document Type LEGAL DOCS

Document Title PROOF OF SERVICE

Date of document following Document Separator Sheet

Document Date _____
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Author UNIFORM ASSIGNED NAME

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MM/DD/YYYY

DWC-CA form 10232.2

Proof of Service
with
Declaration of Readiness to Proceed,
Answer to Application for Adjudication of Claim, 4906(g) and
Medical Reports